



Aesthetic Society News

Quarterly Newsletter of the American Society for Aesthetic Plastic Surgery

Volume 10, Number 4

Fall 2006

Virtual Advice, Real Risk

By Bob Aicher, Esq. and Marie Czenko Kuechel

Electronic communication has become a way of life—and an essential to the business of plastic surgery. As aesthetic surgery information becomes pervasive on the Internet, maximizing your exposure on the web requires creating a response mechanism whereby prospective patients can not only learn about you and the services you provide, but also can reach out and make contact. Whether your own website, an on-line directory service or other template, nearly every place that you have exposure on the web likely allows visitors a click to “Contact the Doctor,” “Email our Office,” “Schedule an Appointment” or “Consult with the Doctor.” But today, electronic



Bob Aicher, Esq.



Marie Czenko Kuechel

communication is reaching beyond that first contact. Many practices are finding it convenient to regularly communicate with patients electronically.

Appointment reminders, satisfaction surveys, on-line newsletters, practice updates and even procedural updates can all be accomplished via email.

This may seem like an ideal form of patient and prospective patient communication. Electronic communication is inexpensive, reliable, 24/7, assumed to be private, reaching worldwide, and easy for your patients and prospective patients to use. But there are cautions, costs and risks. No matter the method of communi-

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Case of the Month



Do you ever wish you could collaborate with your aesthetic colleagues on a particular case that presents to your practice right now?

Now you can. Starting this month, we are introducing a new feature to our online educational opportunities called Case of the Month. We'll be emailing you a particular clinical situation and asking for your advice on approach and outcome. The discussion will take place on the member's only message board and be moderated by President Jim Stuzin, MD and President-elect Foad Nahai, MD. The results of your discussion will be published in future issues of *ASN*. We hope you'll take advantage of this interesting challenge.

Society Issues Patient Safety Video News Release Specifically Aimed to the Hispanic Market

Responding to what members call a “serious issue” the Aesthetic Society is producing a video news release (VNR) advising the Hispanic and Latin American communities to be particularly careful when considering offers of “too good to be true” cosmetic procedures. New reports have appeared from California to Massachusetts with disturbing stories of non-physicians performing lipoplasty and other surgical procedures in basement “operating rooms” and unsuspecting individuals being injected with liquid silicone, cooking oil and other substances leading to disfigurement and death.

“As the leading organization of aesthetic surgeons in the world, we feel a special obligation to get out our messages of accredited facilities, board certification and thoroughly doing your homework before embarking on any medical procedure to communities that need this information the most,” said Felmont (Monte) Eaves, III, MD, Chair of the Patient Safety Committee. The release will be produced by the award winning broadcast company, TeleNoticias, whose primary focus is the Hispanic market. The spot will feature Aesthetic Society member Christian Guzman, MD as chief spokesperson and is scheduled for a late fall release.

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Aesthetic Society News

The American Society for Aesthetic Plastic Surgery
The Aesthetic Surgery Education and Research Foundation

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The American Society for
Aesthetic Plastic Surgery



The Aesthetic Surgery Education
and Research Foundation

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ASAPS Members Forum: www.surgery.org/members

ASAPS Website: www.surgery.org

ASERF Website: www.aserf.org

November 12-16, 2006

Advances in Aesthetic Plastic Surgery—The Cutting Edge VI

New York Hilton

New York, NY

Contact: Francine Leinhardt

Tel: 212-702-7728

December 1-3, 2006

QMP Second Aesthetic Surgery Symposium

Chicago, IL

Contact: Andrew Berger

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Tel: 314-878-7808

January 26-28, 2007

12th Annual New Horizons in Cosmetic Surgery Symposium

Renaissance Esmeralda Hotel

Indian Wells, CA

Co-sponsored by

ASAPS/ASERF/ASPS/PSEF

Contact: PSEF

Tel: 800-766-4955

February 15-17, 2007

41st Baker Gordon Symposium on Cosmetic Surgery

Hyatt Regency Miami

Miami, FL

Contact: Mary Felpeto

Tel: 305-859-8250



April 19-24, 2007

The Aesthetic Meeting 2007—Annual Meeting of ASAPS & ASERF

Javits Convention Center

New York, NY

Contact: ASAPS

www.surgery.org/meeting2007

Tel: 800-364-2147

Meeting: July 20-28, 2007 Cruise: July 21-28, 2007

Aesthetic Surgery on the Baltic—Biennial Cruise

Co-sponsored by

ASAPS/ASERF/ASPS/PSEF

Contact: ASAPS

www.surgery.org/cruise2007

Tel: 800-364-2147

August 22-25, 2007

22nd Annual Breast Surgery and Body Contouring Symposium

El Dorado Hotel

Santa Fe, NM

Co-sponsored by

ASAPS/ASERF/ASPS/PSEF

Contact: PSEF

800-766-4955



Something to celebrate

This year marks the 40th Anniversary of the Aesthetic Society, a milestone that should not go unnoticed, for it was nineteen sixty-seven that marked a seminal change for our specialty and the educational opportunities available to it.

Isaac Newton said "If I have seen further it is by standing on the shoulders of Giants," and I am happy to report that many of the original giants who started the Aesthetic Society are still actively involved in the group and contributing their wisdom and experience to all members.

It is no surprise that we all have a lot to learn from them. With this in mind, we are starting a new feature in ASN titled: "Focus on Life Members." Our inaugural profile is an interview between ASN Editor Julius Few, MD and Dr. Lawrence Robbins, an aesthetic leader from my hometown of Miami, Florida and a past president of ASAPS. Larry Robbins has spent more than 35 years providing patient care, training residents and serving on numerous boards and committees. He still brings his teaching skills everywhere from Rio to South Africa. Larry's main message to new members? "You must give back to contribute to the specialty."

As education has always been and continues to be the Mission of ASAPS, we are introducing a new feature that should be both fun and informative. Case of the Month features an aesthetic situation one of our colleagues have encountered and gives you the opportunity to discuss online how you would approach it and what the optimal result would be. The discussion will be "moderated" by Foad Nahai and I with the results published in future ASN issues.

In this issue

This issue of ASN features articles from three sources well known to attendees of our Annual Meeting. Wendy Lewis, a long time and highly respected consultant to our industry offers her perspective on Understanding the Cosmetic Patient. Wendy had such a wealth of information to share we are running this as a two part series.

Email and other internet communications are more and more the norm in aesthetic surgery practices. But is the right way for us to be communicating with patients? Marie Czenko Kuechel has collaborated with ASAPS corporate counsel Bob Aicher to explore both the advantages and potential risks of this delivery system. This article is important reading for any of us with a busy surgical practice.

David Mandell is a relatively new addition to our annual meeting program but his expertise in financial management reflects the wisdom of an opinion leader in the field. You'll find his article on retirement plans on page sixteen of this issue.

In the news

Nasal plastic surgery appears to improve nasal airway function in patients with severe nasal obstructions, according to a report in the September/October issue of *Archives of Facial Plastic Surgery*.

Obstruction of the nasal passages is one of the most common conditions treated by otolaryngologists and facial plastic surgeons, according to background information in the article. Common causes include septal deviation, which occurs when the wall separating the two nasal passages is crooked or off-center; valve insufficiency, caused by improper positioning or collapse of cartilage inside the nasal passages; and turbinate hypertrophy, when

air flow is blocked by large or swollen turbinates, areas inside the nose covered by mucous membranes that help warm and filter incoming air.

Judges Going to School for Training in Science

Scores of judges are going to a new kind of medical school, not to become doctors, but science-grounded jurists.

Judges in several states are participating in a new program in which they attend science classes, taught by doctors and scientists, so they can better understand and interpret cases that involve complex scientific theories.

Such cases—whether they be medical malpractice, products liability or intellectual property suits—are increasingly popping up in their courts. If judges are to be the gatekeepers of scientific evidence, as the 1993 U.S. Supreme Court's decision in *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993), has mandated, then more knowledge of science is essential.

"What we're seeing are more and more cases that hinge on very extremely complicated scientific principles," said Ohio trial judge Lee Sinclair, adding that judges are under increasing pressure to weed out unreliable medical testimony. "Is this really science or is it junk? That's a huge thing right now, in any type of litigation."

Upcoming events

The inside cover of ASN lists a variety of educational opportunities endorsed, co-sponsored or sponsored by the Aesthetic Society. I urge you to investigate them and keep current on the plethora of clinical options we now have available to our patients.



Understanding Cosmetic Patients: New Insights into what Makes Them Tick

The First of a Two Part Series By Wendy Lewis

Health care is one of the only industries that has fostered the attitude of leaving the customer out of the equation. Whereas that culture may suffice in the realm of managed care, plastic surgeons do not have that luxury. Patient-initiated cosmetic surgery is fundamentally different than medically necessary surgery. Therefore, patients have unique expectations both about the results and surrounding the whole process. When it comes to elective cosmetic procedures, delivering what the customer or patient wants often comes even before what the patient really needs. If you give your patients what you think they need and discount what they want, the end result can be a fatal breakdown in doctor-patient communication.

A 2006 report of the Institute of Medicine entitled *Performance Measurement: Accelerating Improvement*, identifies the following six main characteristics of quality health care: that it is safe, equitable, evidence-based, timely, efficient, and patient-centered.¹ The first three objectives are controlled by the physician, whereas the next three are directly influenced by patient satisfaction.

"Everyone gives lip service to a commitment to give the best patient care, but that standard is relative. The most fundamental concern for patients is a reasonable level of skill and patient commitment. Is the physician not only a qualified surgeon but also a caring doctor who is there for the patient following surgery? The greatest burden on surgeons performing elective cosmetic surgery is to do no harm, and both meticulous intraoperative technique and postoperative care is the key to an uneventful recovery and a result that is satisfying to both the patient and the physician," says Dr. James M. Stuzin in Miami, Florida, President of ASAPS.

Perhaps the next most important concern is that the patient be treated with



respect, as an individual with unique goals. Being treated with respect means being given the information they need and services that are appropriate for them. "You cannot do the same operation on every patient, and another essential element to successful results is to individualize the treatment plan according to the aesthetic needs of the patient," says Dr. Stuzin. "Of course, the patient needs to be an integral part of the process, and what the patient expects and what the physician can deliver need to be congruent."

Taking the High Road

The delivery of a first class product is paramount when you are building an aesthetic practice. This single element will either catapult you to success if you do it well, or come back to haunt you if you miss the mark. The best advice for younger plastic surgeons starting out, according to Dr. Alan Gold in Great Neck, New York, ASAPS Vice-President, is to "Understand

your general strengths and weaknesses, and most importantly know your surgical limitations. Your greatest source of referrals will be your satisfied patients, and you should cherish and cultivate them."

The most important investment any plastic surgeon has is his professional reputation. Once that is tarnished, you can never get it back.

Faced with the overwhelming financial burden of starting a cosmetic practice, some plastic surgeons may attempt to cut corners on the important things such as staffing and building out their facility. There is no way to have a practice that can effectively treat the wide array of concerns of cosmetic patients without creating an infrastructure suitable to service them.

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Understanding Cosmetic Patients

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For example, getting by with a part time person or utilizing your scrub nurse or receptionist to serve in the role of patient coordinator rarely works in the long term. In addition, it is important to choose the products and devices you use with diligence. Everything you offer in your practice is a reflection of your credibility as a physician. Rather than trying to save a few dollars on a cheaper laser or illegally importing dermal fillers, investigate all your options and choose quality and value over price alone.

The philosophy of continuous improvement applies to every facet of a plastic surgery practice as a whole. Never underestimate the advantages of additional training and continuing education courses for yourself as well as key members of your staff. Even the most experienced senior plastic surgeons know that they cannot possibly know everything, and they are not above learning a new technique or a new twist on an established method. There is always something that can be learned from your colleagues, as well as your patients, in this evolving specialty of aesthetic medicine.

As you evaluate new technology and procedures, not every technological advance is going to be a worthwhile adjunct. When new techniques arise, it behooves plastic surgeons to make an honest appraisal to determine whether the potential benefits outweigh the risks. We have all seen many procedures come and go, but you have to make quality the core of your practice values, philosophy and mission.

"In an aesthetic surgery practice," Dr. Malcolm Paul in Newport Beach, California, Past President of ASAPS and National Secretary for ISAPS, explains, "we have to be prepared to look at our procedures and results objectively, and to constantly improve how we are doing things. We have to stay current and pay attention to new developments. Cosmetic patients are very savvy, and they are no longer satisfied to have things done the same way they have been done for decades. They want a plastic surgeon who is willing to change his philosophy or technique as new concepts evolve that offer advantages."

Doctor, Make Me Beautiful

More than ever before, plastic surgeons are faced with the need to educate their patients, set realistic expectations, and choose the right technique for the right patient at the right time. Sometimes this will mean bypassing the newest gadgets or techniques available, for those that have stood the tests of time and peer review. "My commitment to my patients is to assure their safety, comfort, and privacy. With that comes the responsibility of selecting procedures that serve the patients' best interest," says Dr. Foad Nahai in Atlanta, Georgia, President-Elect of ASAPS.

Your staff can also be your most valuable asset, or your downfall if you are not paying attention. Plastic surgeons should take a close look at their staff periodically, and reassess whether they have the right people on the bus.

In this era of total transformation surgery, it is vital to try to get the patient to focus on what bothers her or him most. By urging patients to prioritize—i.e., face vs. body, or eyes and nose vs. breasts and liposuction—you can map out a long term plan for them that is safe, sensible, and affordable. Start with the first stage and hopefully they will come back for other procedures or treatments over time, and you will have a lifelong patient. But patients today have a lot of choices, and there is always a chance that even if you did a terrific job, the patient will never come back for more, will choose another doctor, or will move out of your area. In some cases, it may have nothing to do with your results or your practice. The patient may simply decide that he or she cannot afford to take time off of work, or pay the price of additional surgeries, or repeat treatments with botulinum toxin every four months. Most people just don't have the resources to tackle more than one stage of procedures at a time. It is like renovating your home. Although you

might be tempted to tear it down and rebuild from the ground up, you are probably more likely to do a little bit at a time. You might slap on a coat of paint, change the wallpaper, upgrade to a Sub Zero® this year, and tackle the master bedroom in a year or two.

Although it may be difficult at times to resist yielding to often misguided and unreasonable patient demands, plastic surgeons have an overriding responsibility to ensure that the scope of the procedures they offer serve their patients' overall best interests. It is much easier to get into trouble by operating on every patient you see, than to master effective patient screening.

Another point to consider, adds Dr. Gold, is not to alienate the medical community (which can be a major source of referral) with too much self-promotion.

Plastic surgeons who do not succumb to the lure of overexposure and glitz and glamour may be as busy as they want to be throughout their careers. In many cases, striving to be the "doctor of the month" may have its short term rewards and long term disadvantages. Your phone will ring off the hook at first, and you will be booked for two years out, but you will have lost credibility with your peers and many of your existing patients. The most important investment any plastic surgeon has is his professional reputation. Once that is tarnished, you can never get it back.

Assessing Your Own Practice

Unless you approach your practice with a critical eye, you will never improve. Look at your practice objectively and figure out what needs improvement and what you're doing wrong or could do better, rather than feeling confident that you are doing everything right.

Your staff can also be your most valuable asset, or your downfall if you are not paying attention. Plastic surgeons should take a close look at their staff periodically, and reassess whether they have the right people on the bus. Treating patients well is not something that you can teach. There is no formal training course that can show people how to be friendly, warm, or caring. It is either in their DNA, or it's

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Key Questions to Ask When Considering a Medical Spa

Part One

By P.S. Piland, Allergan Practice Consulting Group, Allergan, Inc.

Medical spas can help boost practice revenue, but they're not right for every practice. Ask these questions to ensure that such a large investment is right for you.

Competition for the cosmetic patient has grown considerably over the past few years. Medi-spas and/or laser centers appear to be opening around every corner, which makes one wonder when the big coffee shops are going to start offering a “laser-with-your-latte” special. Everyone seems to want to take advantage of what appears to be a quick and easy money-making opportunity.

Physicians with whom I work get excited once they make the decision to open a spa at their practices. They want to move quickly and enter the market “before it is too late.” Once the stampede has started it is difficult to pull the reigns, but slowing down and considering all factors is imperative so that you do it right the first time. A well-thought, methodical approach is the best course of action when considering this kind of endeavor. As coaching legend Paul Bryant said, it's not the will to win, but the will to prepare to win that makes the difference. This first of a two part series concluding next month, will address a variety of questions that physicians should consider before making a decision to enter the medical spa arena.

SWOT Analysis

A useful subjective tool to use when beginning the strategic planning process is the SWOT analysis. SWOT is an acronym that stands for:

- Strengths
- Weaknesses
- Opportunities
- Threats

You can use a SWOT analysis to measure the internal and external factors that will affect your decision to enter the medical spa market. It will also help define the degree of success that is attainable.

The SWOT analysis is most often presented in a four box grid. Strengths and weaknesses address internal factors, while opportunities and threats address external factors. The strengths of your practice are your resources and capabilities that can be used as a basis for developing your competitive advantage. Some examples of strengths may include your reputation among patients as a high quality medical care provider, your unique skills or areas in which you excel compared to anyone else in your market, or your staff. The weaknesses are, in essence, the absence of certain strengths. They may include the inverse of the above listed strengths.



Opportunities may be external factors that can be used for increased profit and growth. A useful approach to identify opportunities begins with examining your strengths and asking if these create any opportunities. You can do the same with the weaknesses; ask yourself if you can identify any opportunities by eliminating specific weaknesses. Some examples may include the absence of a medical spa in your area, strategic alliances, a medical spa



P.S. Piland

that recently closed in your area, or demographic changes. Threats may include a new physician or medical spa in your area, a competitor who was first to enter the market, shifts in consumer needs, or competitor price wars.

A SWOT analysis will be most useful in aligning your practice's resources and capabilities to the competitive environment. It will help provide a framework and direction for this initiative. Importantly, be realistic and honest with yourself while examining your strengths and weaknesses. Remember to be specific, base your self-analysis on a comparison to your competitors, and keep the process as simple as possible.

The Right Questions

Once you complete the SWOT analysis, if you are still contemplating a medical spa for your own practice, it's important to ask and answer several key questions. I spoke with Kenneth Beer, MD, a physician in private practice and owner of a medical spa in Miami, FL, and Devon Boggs, a practice administrator for Sarasota Plastic Surgery, also in Florida, to pinpoint several questions to ponder.

1) Where are the patients?

For a relatively significant period of time, physicians and medical practices have recognized that cosmetic patients are being drawn away by a variety of different

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Key Questions

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sources. Providers have been searching for new ways to respond to this “encroachment” upon their patients. One option has been to expand the services offered by the practice. A medical spa is one way to achieve this goal. The International Spa Association (ISPA) reports that consumers made 136 million spa visits in the United States in 2003, spending a total of \$11.2 billion. ISPA also notes medical spas are the fastest growing segment of the spa industry. This is a tempting revenue stream to the medical community and one that should be considered, albeit carefully and with an eye out for both the pros and cons of such an undertaking.

2) How difficult is it to open a medical spa?

Opening a medical spa is similar to the process of opening a surgical center or a medical practice. While opening a medical spa will likely be somewhat less complicated than opening a surgical center due to the regulations involved with a surgery center, it still presents many of the same challenges. This is a major undertaking; you are not simply thinking of adding a service or offering, but potentially adding a whole new dimension to your practice.

3) What is the goal in opening a medical spa?

Practices that ultimately choose to expand their aesthetic services do so for a number of reasons and with a variety of goals or motivations in mind. The following is a look at the most common reasons practices give for expanding their cosmetic service offerings:

“I want to increase my patient retention rate by expanding the services currently offered within my practice.”

The underlying goal is to satisfy the needs of current patients. This is a good defensive posture to take. The thought is if you can limit your patients’ exposure to other practices or spas, then you may have a better chance to keep them in your practice. Once you have achieved this, you can focus your efforts upon moving them up the ladder of cosmetic procedures. Patient retention is critical to the success of any practice. To help reinforce this strategy, consider these well-known statistics:

- Cost: It costs five times more to attract a new patient than to keep an existing one.
- Profit: Retaining merely five percent more existing patients produces a 25 percent increase in profit.
- Referrals: Happy patients tell four to five others; dissatisfied patients tell nine to 12!
- Pricing: Satisfied patients demonstrate less price sensitivity.

“I want to draw more patients to my medical practice.” This is one of the more popular goals or motivations among physicians considering a medical spa. This requires clear communication to the medical spa staff of your objectives and expectations. It is important that the medical spa customer does not feel he or she is being forced into a high pressure sales environment. One way to avoid this is to create an environment conducive to patient education. This can be achieved in several ways. A cosmetic interest questionnaire can be used when the medical spa customer is checking in. This will help create awareness of all of the services available. It also moves the conversation towards educating the customer on topics they have shown an interest in. You should have (or create) a detailed menu of services that lists what is offered by both the medical spa and the medical practice. This is an excellent form of internal marketing. You are creating an awareness of what you offer. Professional vendor brochures on specific procedures like Botox®, breast augmentation, cosmeceuticals, etc. can help provide more detailed information.

“I want to have a stand-alone medical spa that will generate big profits quickly without my involvement.” Setting realistic goals is important to achieve success. If this is your goal, you will most likely be disappointed.

In next month’s article, we will go over specific details pertaining to the maintenance, staffing, and management of a medical spa as Dr. Beer and Ms. Boggs offer more practical tips for running your practice and medical spa.

One Tip

When asked to offer “one tip to a physician considering opening a medical spa,” Dr. Beer and Ms. Boggs had this to say...

Dr. Beer: “From my experience, spas make money only insofar as they refer patients back to the physician or medical practice for Botox®, liposuction, laser, etc. By themselves, medical spas are not the profit centers that many physicians, myself included, thought they would be. They can be wonderful sources of revenue if your staff sells a lot of product and if the spa is attached to the office, thus encouraging a free flow of patients. The downside is that you have another set of employees that bring their own issues, and you will alienate some patients that see the med spa business as ‘selling out.’ You have to balance this with the potential referrals and revenue that a spa can bring.”

Ms Boggs: “Don’t go into this project half-hearted or unprepared. Give yourself more time than you think you will need to open it because there are so many details to manage.”

Mr. Piland: “I have observed medical spas that weren’t successful and ended up losing money. One recurring theme was insufficient planning. This brings to mind an old, but true, adage: if you fail to plan, you plan to fail. Remember the five Ps for success: Prior Planning Prevents Poor Performance.”

PS Piland is a consultant in the practice relations area of Allergan. Part two of his medi spa article will appear in the Winter issue of ASN.



On Establishing a Medical Spa

A Surgeon's View

By Renato Saltz, MD

The article by PS Piland is an excellent overview on the key questions to ask when considering incorporating a medical spa into your practice.

The following are some of my recommendations based on personal experience. My comments are limited since I have had the medical spa for a little short of four years and can not offer to the reader a five to ten year perspective in this business. With that in mind, here is a brief summary of my extensive preparation before I joined what is often called a "non-surgical" field.

I will also share with you the distinct feeling of running a business "outside an operating room" and often not delivering results as we have learned to deliver after many years of plastic surgical training.

I would add to coaching legend Paul Bryant's famous saying "it's not the will to win but the will to prepare to win that makes the difference" and say to my colleagues that are contemplating such a project that the preparation continues on a daily basis and sometimes it feels you will never win...

Are Medspas the Environment of the Future?

The Data Monitor predicts for 2006:

- Spa facial care will rise 6,7% annually to \$857 million.
- Spa body care will increase 10,5% annually to \$150 million
- Cosmeceuticals are projected to reach \$7.2 billion
- The business of medical spas will explode into a \$ 1 billion industry.

For some of our colleagues it is still quite hard to accept the fact that "the knife" does not deliver everything we thought our patients wanted from us anymore. However, patients today want quick and effective solutions. They want real results; they want them immediately

and want the results to last. Our patients want to be pampered and be taken care off. They are very educated and are continually "advised" by fashion and health magazines, internet, their hairdresser and most importantly their best friend. They are fully aware of "what's next" and many of them are not prepared to have surgery...yet!

In creating my own spa I followed the outline below:

- The vision
- Location & staff
- Patients
- Surgery, service and products
- Liability
- Community service & volunteering
- The bottom line

Vision

I found that it is important to have a vision of where your practice will be in five to ten years and to remember that successful practice management is more than money management.

In the late 90s I tried to develop a small medical spa in a university setting. I faced many intellectual, emotional and financial barriers. All I wanted was a place for my surgical patients (aesthetic and reconstructive) to be seen by a medical aesthetician before and after facial surgery, to be counseled by a nutritionist and physical therapist/trainer before and after their body contouring procedures and have lymphatic drainage massage after surgery. It never happened.

After much frustration I realized this "new mainstream" had to be built and would never happen in an "old normal."

In 2002, I opened Spa Vitoria, a Medical Spa adjacent to my private practice clinic in Salt Lake City and Park City, Utah. The procedures were all performed

by nurses, certified medical aestheticians, certified lymphatic massage therapist all under my direct supervision. By 2003 I added some more traditional spa treatments to help to pay the bills.

Location & Staff

Location and the right staff are critical to the success of your practice. Employees are physician extenders and you should hire employees with the same high standards you have for patient care and safety.

Patients

Your patients will make or break your practice. Excellent ASAPS Instructional Courses given by Karen Zupko and Mary Jewell can educate you in how to capture and most importantly how to keep patients in your practice.

I have used all their teachings and have been able to save a lot of money by promoting the Medical Spa through internal marketing using the large pool of my aesthetic and reconstructive patients achieved over the past 15 years in practice. The "four key steps" so cleverly advocated by Karen Zupko have done wonders for my surgical practice. Today I apply them to the Medical Spa. And all starts with the first phone call...

Surgery, Services and Products

The benefit of incorporating a medical spa to your practice is summarized by what I call "The Complete Aesthetic Package". The patient benefits during the pre-operative, intra-operative and post-operative phases from different modalities of treatments that will affect the outcome of the surgery and enhance the results.

The "team approach" concept will help to select the best modalities of treatment especially during the pre and post-operative periods. For example, the facial

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On Establishing a Medical Spa

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package before a face lift will include an aggressive approach to exfoliation, skin care and sun prevention supervised by one of our certified medical aestheticians. Photofacial treatments to remove hyperpigmentation caused by sun damage can be added at this time or post-operative. Other facial treatments like Botox[®], soft tissue fillers and Thermage[®] can be indicated at this time.

The intra-operative surgical management can benefit from techniques that contribute to a shorter recovery, less bruising, less swelling and avoidance of drains, particularly on procedures like endoscopic brow and midface. All my skin incisions are approximated with Dermabond[®] after buried dermal absorbable sutures. They can get wet immediately.

Post-operative, our certified lymphatic massage therapist has helped my facial patients immensely, by decreasing their lymphatic swelling, their bruising and most times just by being there helping patients deal with their postoperative fears, discomforts and often lack of attention that they need so much and we surgeons/nurses are not available to give due to our busy schedule.

Early post-operative camouflage make

up is also useful to keep the patients out of the house and back to their regular social activities. Skin care and sun protection is resumed early and maintained forever.

Other treatments mentioned above can be applied post-operatively and continued on regular basis as indicated by the physician and aesthetician.

A similar concept is applied to body contouring surgery patients and called “the complete body aesthetic package” which also includes patients for breast reconstruction after mastectomy. Pain pumps to decrease early post-operative pain and DVT/PE prophylaxis for safety reasons are important components of the intra-operative portion of the body aesthetic package.

Finally, Medical Spa services can help to prepare your patient for surgery in four different areas:

- Physical preparation—to improve skin and body condition
- Emotional preparation—pre and post-operative care understanding
- Intellectual preparation—educated on all aspects including safety issues
- Financially preparation—educated on the investment

The world of cosmeceuticals contin-

ues to grow. Be sure you understand the products and how they can improve (and also damage) your patient's skin. Test all new products and be sure to educate your patients regarding possible complications. In the liability section I will expand more on this issue.

Liability

Plastic Surgery News from August 2006 summarized quite well how medical spas can increase your exposure to liability:

“The increase in liability from mistakes of ancillary personnel, from the facility itself and from products and treatments. There have been 16 cases against medical spas since 1988, with the average plaintiffs award was \$500,000. They were divided in three categories: medical liability, premises or personal injury liability and worker's rights. The same article emphasizes some of the difficult issues still facing the national regulation of medical spas since the qualification to perform certain procedures changes from state to state. Most often the lawsuits involved spa services performed by unqualified, unsupervised personnel.”

There are at this time no websites or other resources that provides up-to-date information about changing laws. The best advice to owners is coming now from their local health law attorney. Most importantly the surgeon should give the same attention to legal responsibilities for the medical spa as for the medical practice.

The medical aesthetic businesses are especially vulnerable to product liability lawsuits, so be careful what you sell and what protections you should put in place.

If a defective product injures someone, everyone in the chain of distribution is liable! The key to avoid product liability is to counsel clients on proper use of the products and warn of the risks if the products are not used properly. Most importantly buy good, solid product liability insurance.

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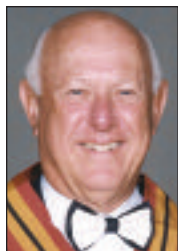
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“You Must Pay Back to Contribute to the Specialty” A conversation with Lawrence Robbins, MD



Lawrence Robbins, MD

I first met Dr. Lawrence Robbins during this year’s annual meeting in Orlando. He met me playing with my 16-month-old son. He made an impression on me, he said, “The most important thing we do is give back to our family/friends and those is need”.



Julius Few, MD

Dr. Robbins is a past President and Chairman of the Board of Trustees of the Aesthetic Society, where one of his major accomplishments was

the creation of a task force for the development of plastic surgery fellowship training accreditation. Dr. Robbins has been awarded such honors as the Distinguished Achievement Award from Albert Einstein College of Medicine, was elected as an associate member of the Millard Society, and was nominated to the prestigious American Board of Plastic Surgery.

In the mid-1980s, Dr. Robbins was the first recipient of the Harold S. Strasser MD Good Samaritan award by the Florida Medical Association. When an explosion sent 180 people to Mt. Sinai Hospital, Dr. Robbins triaged and treated many of these patients with severe burns. He continued treatment on 23 of them for over a year—pro bono. One of his more recent awards was from the Plastic Surgery Education and Research Foundation for Excellence in Education.

If this sounds more like a testimonial than an interview, I ask the readers indulgence. The Larry Robbins I interviewed for this issue of ASN is a dynamic and well versed surgeon, with a special interest in education. Although now retired from active practice, he has certainly not retired

from a life-long interest in aesthetic surgery—as you will see from the following conversation:

Dr. Few:

Larry, you’ve had a career that spans more than 30 years. Is there one accomplishment you are most proud of?

Dr. Robbins:

That’s a difficult question to answer. I’m honored to be speaking with you in this interview. I was honored when I was recognized by Miami Beach High School. But you asked me about accomplishments, not recognition. I can honestly say that aside from the love of my family and friends, my greatest accomplishment was being a trusted plastic surgeon for most of my life.

See, you don’t gain the trust of patients by receiving plaques or running advertisements or getting on TV shows. You have to earn a reputation, and the only way to do that is by treating patients the way you would want to be treated and providing the best care you possibly can. You can’t buy a reputation, you have to earn it.

Dr. Few:

Many think of you as an educator. Would you comment on that?

Dr. Robbins:

See, that to me is another great honor. What a wonderful thing to be known for! It’s true that medical education has always been a big interest of mine. I was lucky to have dual faculty appointments at the University of Miami and Stanford. I would get these people in fellowships and they would spend six months to a year on “on the job training.” Some of them have gone on to pretty important positions.

It all started when I was Chief of Plastic Surgery at Mt. Sinai Medical Center. You see, back in the mid-seventies it was still very difficult for those interested in

the aesthetic aspects of plastic surgery to get post graduate education. So I started a program in aesthetic surgery that I think trained about 50 individuals.

Dr. Few:

That you funded with your own money...

Dr. Robbins:

I suppose so but that’s not really the point. If someone has an interest in a particular aspect of medicine than I feel we have an obligation to provide it to the best of our abilities. You know, one interesting thing about this program is that I had the great privilege of meeting with the president of Israel and with Moshe Dyan about the program. Our fellowship actually started with an Israeli surgeon and he stayed at the house with us for about a year.

Dr. Few:

That must have been an exciting time...

Dr. Robbins:

This is an exciting time! I can’t explain it but people still seek me out for presentations, traveling professorships, magazine interviews—and I’ve been retired for eight years. Plastic surgery has been very good to me and I think it’s very important to give back.

Dr. Few:

In closing, is there anything you would like to say to young surgeons just establishing their practice?

Dr. Robbins:

You ask the hard questions, don’t you! Well when it comes to professional organizations, don’t choose one over the other. ASPS and ASAPS are complementary and both offer unique benefits. Don’t rely on advertising or websites or press releases to establish a reputation. Hard work does that. And don’t forget that as a physician you are an important part of the community. Remember to give back.

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Virtual Advice, Real Risk

Continued from Cover

cation you use with your prospective patients and patients, practices should be efficient, effective, appropriate, personable and within the legal and practical standards of medicine, the personal services industry and as a member of the Aesthetic Society.

Perception vs. Reality and Risk

You want any communication about you or your practice to contain an easy, and compelling means for prospective patients to make contact. Logically, if the source is electronic, the means of contact is electronic. But logic isn't always a best practice.

Cost: *Electronic communication comes at a perceived flat rate: you pay a monthly service, not per email. But is this really less costly than paper, envelope and first class postage or a human being and telephone service?*

Budget human resources to electronic communication, compel your audience to personal communication (telephone or an office visit) within all your electronic messages, and when appropriate, respond personally rather than electronically.

Reality: Electronic communication incurs the cost of time and the human resources necessary to communicate electronically with prospective patients and to manage information. But, the real cost to electronic communication is a loss of human contact. In a practice focused on personal service, the human element is essential.

Budget human resources to electronic communication, compel your audience to personal communication (telephone or an office visit) within all your electronic messages, and when appropriate, respond personally rather than electronically. Electronic communication is, in fact, cheap for both users, and so you may find

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Virtual Malpractice?

Can email result in malpractice? Yes. While email with your patients is much more likely to present a privacy risk, it can also be a malpractice risk if you create a physician-patient relationship. The greatest risk is patient anonymity and the absence of visual and auditory cues that would alert you to potential problems.

Can e-mail get you disciplined out of state? Yes, so before you start giving advice to patients out of state, ask yourself, do you need to be licensed in that patient's state? Many say yes, because your electronic advice with that patient demonstrates you are practicing medicine in that state. Simply stated, if you are doing business there, you might be disciplined there.

Can websites also get you sued out of state? Yes, if they start to look like interactive e-mail. Websites are divided into three categories: passive (info only, no out-of-state jurisdiction), active (interactive or product sales, guaranteed out-of-state jurisdiction) or blended (requiring analysis). Web-based information-only communications, such as scheduling appointments, aren't enough, but interactive websites which provide for requesting and giving medical advice, or shipment of skin care products, will be sufficient for out of state jurisdiction. T

Website Cases for the Defense

Harlow v. Children's Hospital (1st Cir. 2005) [Massachusetts hospital couldn't be sued in Maine where its website conducted no sales or business]

Kelly v. Echols (E.D.CA 2005) [Filling out online questionnaire created no physician-patient relationship with North Carolina internet pharmacy]

Visage Spa, LLC v. Salon Visage, Inc. (E.D.MI 2006) [Plastic surgeon's use of infringing trademark insufficient to overcome passive website, suit dismissed]

Website Case for the Defense, but Telephonic Case for the Plaintiff

Schexnayder v. Daniels (TX 2006) [Informational website insufficient, but telephonic direction of Texas surgery and care sufficient to sue Arkansas physician in Texas]

Website Case for the Plaintiff

Jones v. ND State Board of Medical Examiners (ND 2005) [Physician disciplined for filling prescriptions based only on online questionnaire]

E-Mail Cases for the Plaintiff

Workgroup Tech. Corp. v. MGM Grand Hotel (MA 2003) [4 calls, 5 e-mails and 3 faxes sufficient to sue Nevada corporation in Massachusetts]

Edwards v. Erdey (OH 2001) [Extended e-mail exchange sufficient to sue Cayman Island eye surgeons in Ohio]

Virtual Advice, Real Risk

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your human resources bogged down in communicating with “shoppers” rather than servicing quality prospects.

In terms of existing patients, consider the value of your message before using electronic communications: There is a real cost attached to patient reactions after reading bad news on a computer screen than hearing it from the surgeon.

Reliability: *Electronic messages rarely get “lost in the mail” and if they do, the sender typically gets a delivery failure notice. Even further, some email programs allow you to receive an automated reply when the recipient has opened your message.*

A message received is only of value if it is understood, and if there is a reply. If a recipient does not reply, you have no way of knowing the reason why, unless you take the time to contact the recipient again.

Messages need to be simple, direct and allow for questions and a dialogue. Use automated return replies to measure what is delivered, and what is opened (and assumingly read). Establish different email addresses for both existing and prospective patients, and for different points of origin so that you can monitor the response rates by point of origin. You may find some



services you subscribe to are generating contact, without generating business.

24/7: *Quite simply, your office and your audience can email you, read and respond to one another's communication at any moment, any time of day or night that is convenient to the user.*

Be clear and concise on policy. From the initial point of contact, you must tell your prospective or existing patient, or anyone who may be e-mailing you that you don't give e-advice, you give advice after an in-office visit.

The convenience of electronic communication puts two things at risk: time and imperatives. Set clear policy: Always make notation of the date, time, means and individual in your office who has sent communication and monitor when a reply is received. Never assume critical information was received or understood, always follow-up until you are assured of comprehension and a favorable outcome.

Privacy: *Your prospective patient or patient is assumed to be reading your communication in an environment that supports his or her comfort level and need for privacy.*

Privacy means much more than simply being anonymous in a plastic surgery practice, and in an electronic world. Before you engage in or respond to any form of electronic communication, privacy must be assured. An electronic privacy policy must be noted on all electronic communications. Moreover, while the permission of the user is a must, take your policy one step further: Require the user to define communication preferences as a prerequisite to any response, and also inform the user that your practice will, if necessary, notify the user that another means of communication is required if electronic messages are not appropriate.

Worldwide: *The notion of expanding your geographic marketing is exciting. The notion of patients from across the state, the country or the globe with an interest in your services is inspiring.*

Electronic communication does not reveal your prospective patient's location, much less affirm that patient understands your location. And in reality, what percentage of your patients travel cross-town,

Privacy Tip:

No matter how careful you are of your patient's privacy in the office, there are added violations that exist in a virtual environment, namely with patient photographs.

A specific release for placing patient photos on your website is included in the ASAPS Cycle of Care product and on the members-only website. When posting photos, make certain picture files are coded, not named by a patient's name. To protect your patient's privacy, this coding must happen before sending pictures to your webmaster or anywhere out of house.

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Virtual Advice, Real Risk

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across a state, cross-country or across an ocean to see you. Look at your patient population and make certain your website speaks to the majority, and make your location clear to the minority.

If you're looking to grow your traveling patient population, consider the reality that a prospective patient should not, and must not travel for services without an

Procedure should define who in the office will respond to what, with what. It should also set forth how the communication will be recorded/filed, tracked and when and if it should be discarded.

in-person consultation, and the risks incurred by prescribing treatment without a hands-on examination. For this reason, you must have a predefined policy for on-line consultations and convey this at the onset of any relationship. Policy must define the actions your practice requires of any patient before treatment, and the timing of those actions. For example, make clear that the doctor must examine the patient in person before any surgical date is scheduled.

Ease of Use: *Email is generally short, fast, and without barriers. Anyone who can presumably read and write can use email. The reality is that your practice needs qualified, happy patients to thrive.*

The challenge is the effectiveness of the message, and the outcome of the effort using a communication tool that is essential blind and uni-dimensional in a specialty that is highly visual and human-dimensional. In the same manner you have defined policies and procedures for how the telephone is answered or patients are greeted into your office, you need to address how your office will respond to electronic inquiries and you need to state your office policy on electronic communication to those who email you. While a first contact from a prospective

patient may be very personal and detailed, your initial response should be:

- **Attentive:** Restate the person's reason for contacting you so that the user feels his or her message has been read.
- **Standardized:** Privacy standards must be respected and communicated in the initial reply. In addition, basic information about your practice policies on email communication with patients should be defined.
- **Personal:** Initiated and signed by an individual in the office who is the point person for a reply, be that next step another electronic message, a phone call, or a visit. There is a caveat here: if the electronic message was specifically intended for the doctor, or if all of your communication is signed by the doctor, within any message a staff person who will be the point of contact must be clearly defined.

Your ROI: To be effective, office practices must have value. To determine value, you need to define a return on investment.

If you are engaging in electronic communication, which is much more than simply a presence on the web, you need procedures to measure electronic communication as more than simply a referral source.

Procedure should define who in the office will respond to what, with what. It should also set forth how the communication will be recorded/filed, tracked and when and if it should be discarded. Track where email from prospective patients originated. Make a value assessment of the effort (time and money) it takes to convert this prospective patient and weigh this against other means of communicating with prospective patients. Without tracking and a value assessment, you cannot measure the value of the source, be it your own web site, a directory, or even a patient or referral from a colleague via electronic contact.

Virtual Risk Aversion

If you are a risk-averse surgeon, there are steps that can reduce your stress with electronic communication. Specifically, apply these practices to all of the email sent to prospective and current patients:

Include a disclaimer/legend: "This e-mail is informational only. It is not intended for diagnosis and treatment of any health condition, nor is it a substitute for in-office, professional medical advice"

Identify the practice, the supervising physician(s) and the location of the sender in every message. Check with the supervising physician(s) and the sender's Board of Medicine whether a medical license is required to respond to questions with medical advice. (For example: none would be required if a receptionist were to give information/advice to a caller who is scheduling an in-office appointment).

Set rules of communication up front with your patients. Only agree to communicate via email to a patient's private e-mail to which no one else has access. Never communicate with a patient's work e-mail address since employers have automatic access.

Encrypt everything. Don't use attachments that may not be opened, or may not be understood. Use auto-reply messages when out of the office, and offer alternate methods of contact. Alternatively, have messages automatically read by a responsible and knowledgeable person who will know when to contact you.

Be clear and concise on policy. From the initial point of contact, you must tell your prospective or existing patient, or anyone who may be e-mailing you that you don't give e-advice, you give advice after an in-office visit.

Non-Qualified & Non-Traditional Benefit Plans: The Retirement Options You Haven't heard of

David B. Mandell, JD, MBA

As authors of two books on financial planning, including one specifically for physicians, we have had the opportunity to speak with thousands of doctors of various ages over the past decade. What we have seen is that two doctors of the same specialty with similar incomes can have very different income levels in retirement. Why?

Three reasons physicians may have very different qualities of life in retirement are:

1. Devastating Incident (Lost lawsuit or divorce)
2. Poor Investment (Bad limited partnership, medical center, or real estate endeavor)
3. Lack of Attention to Taxes.

Fortunately, “qualified,” “non-qualified,” and “non-traditional” planning can help you address the three challenges mentioned above in significant ways. Unfortunately, most physicians only utilize traditional “qualified” retirement plans—such as pensions and 401(k)s—which are restrictive and burdensome, while ignoring the more flexible “non-qualified” deferred compensation (“NQDC”) plans and—to an even greater degree—missing out on “non-traditional” benefit plans altogether. In fact, only a handful of the thousands of doctors we have spoken with over the years employ NQDC or non-traditional plans. This is unfortunate.

1. Qualified Plan Basics

The term “qualified” plan (“QP”) means that the retirement plan complies with Department of Labor and Internal Revenue Service rules created under the Employee Retirement and Income Security Act of 1974 (ERISA). These plans may be in the form of a defined benefit plan, profit sharing plan, money purchase plan, 401(k), or 403(b).

Properly structured plans offer a variety of benefits: you can fully deduct contributions to a QP, funds within the QP grow tax-deferred, and (if non-owner employees participate) the funds within a QP enjoy superior asset protection. Despite the benefits QPs can offer, there are a host of disadvantages that physicians must understand:

- Mandated maximum annual contributions for defined contribution plans (\$41,000 for pensions, profit-sharing plans; \$14,000 for 401(k) plans)
- Mandatory inclusion of all eligible employees
- Potential liability for management of employee funds in plan
- Control group and affiliated service group restrictions
- Penalties for withdrawal prior to age 59-1/2
- Required distributions beginning at age 70-1/2
- Full ordinary income taxation of distributions from the plan
- Full ordinary income taxation AND estate taxation of plan balances when you die (combined tax rates on these balances can be over 70%)

Despite these numerous disadvantages, nearly all physicians in the U.S. participate in QPs. The tax deduction is such a strong lure, it often cannot be resisted. For some doctors, this makes sense. But for many, the cost of contributions for employees, potential liability for mismanagement of employee funds, and the ultimate tax

costs on distributions to you and your family may outweigh the current tax savings offered by QPs. Tax and business-savvy physicians may find asset protected after-tax investments more valuable and flexible

to their overall wealth protection plans. This is just another area where “common sense” planning is really what we call “LCD” planning—“lowest common denominator” planning that everyone seems to do, without a sophisticated analysis of all options.

2. SEP-IRAs

SEP-IRAs are not officially QPs—they are custodial accounts, yet, in many ways, they are similar. You have the same tax restrictions on annual contribution amounts, penalties for early withdrawals, mandatory withdrawal rules, and taxation on distributions and plan balances at death as you have with a QP. One big difference is that a SEP-IRA may not enjoy the same level of asset protection as a QP does outside of the bankruptcy context. The protection in that case is not “federally mandated” but rather handled on a state-by-state basis.

3. Non-qualified deferred compensation (NQDC) Basics

Non-qualified plans are relatively unknown to physicians. This is true, despite the fact that most Fortune 1000 companies make non-qualified plans available to their executives. While many of these plans in public companies involve company stock or stock options (which, of course, do not work in a medical practice environment), many use structures that a physician certainly could easily employ in a practice.

Although NQDC plans are not subject to ultra-onerous qualified plan regulations described above, they are subject to some government rules. In fact, Congress recently passed legislation that further regulates NQDC plans. However, a NQDC plan is still attractive for many physicians, when compared to a traditional qualified plan pension or SEP-IRA. The benefits of NQDC plans for physicians include:

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Non-Qualified & Non-Traditional Benefit Plans:

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- More generous contribution limits
- No mandatory participation by employees (you can choose who is offered participation and who is not)
- No control group and affiliated service group restrictions
- No penalties for withdrawal prior to age 59-1/2
- No required distributions beginning at age 70-1/2

One of the main drawbacks of NQDC plans is that the assets in the plan are subject to the claims of the company's (or medical practice's) creditors. For this reason, many physicians looking for more flexible planning structures, as well as asset protection, look outside the qualified and non-qualified planning options—to non-traditional plans that offer benefits for the physician in retirement.

4. Non-Traditional Executive Benefit Plans (NT Plans)

As the word “non-traditional” implies, these are plans that sit outside the regulations pertaining to qualified and NQDC plans. In this way, options that exist vary greatly in structure and can be tailored to meet the physicians' individual goals. While the details of such NT plans are beyond the scope of this article, we will list a couple of options here. As a rule, these plans have all of the benefits of a NQDC plan, plus the following:

- No mandated maximum annual contributions
- Can be structured to be both income and estate tax-efficient

Types of NT Plans

While we will limit our discussion here to a number of popular types of NT plans, we hope that this discussion furthers your interest in NT plans and how they may play a role in your overall financial plan.

1. Compliant Split Dollar Plans

Split dollar plans have been the primary type of NT plans in the corporate work place for the last 40 years. Over the last three years, however, the IRS has changed the rules significantly regarding split dollar plans. Unfortunately, many advisors who do not practice in this area on a daily basis operate under the

misconception that split dollar plans are now “dead.” Nothing could be further from the truth.

Under the new rules, it is certainly more difficult to implement a split dollar plan for public companies. However, for private businesses, including all medical practices, split dollar plans can still be a viable option. In fact, given the low interest rate environment that we currently enjoy, now may be a perfect time to implement a split dollar plan for a medical practice. Physicians can take advantage of this low interest rate (which affects the tax treatment of the structure) and enjoy significant retirement wealth accumulation without offering it to any employees. These types of plans can be structured to handle many of the buyout/buy-in issues between the younger and older partners in a practice. If you want to potentially have more income in retirement and explore tax-efficient ways to transition ownership of a practice, we highly recommend that you consider the advantages and disadvantages of a compliant split dollar NT plan to see if this plan may be right for you.

2. Asset Protection NT Plans

In many circumstances, the central goal of a NT plan may be asset protection for the practice assets. Have you ever been concerned that one of your partner's or employee's mistakes could cause a lawsuit that would decimate all of your practice real estate, equipment and accounts receivable? Many physicians are very concerned about this issue and they are delighted to hear that a solution to their concern can also offer retirement and tax benefits.

Most popular in this arena for physicians are those that asset-protect a practice's accounts receivable (AR). However, in this type of NT plan it is crucial that both asset protection and tax issues be properly negotiated. In most of the plans that we have reviewed, there are common pitfalls lurking in such plans. If this type of plan is of interest to you, we encourage you to contact us.

3. Financed NT Plans

Financed NT plans, when properly structured, can provide the greatest after-tax investment return to the physicians

participating. Because an outside lender puts up the initial capital to fund the plan, but takes back a fixed return, the physicians gain the use of OPM (“other people's money”) compounded on a tax-deferred basis. Further, the plans are typically structured for substantial asset protection against the creditors of both the medical practice and the individual physicians.

Conclusion

Every successful physician should consider a NQDC and/or NT plan based on their personal circumstances. Qualified Plans are burdened with a host of restrictions, costs and tax limitations. This often makes them expensive for the physicians and may not allow for significant retirement wealth accumulation. NQDC plans have much fewer restrictions and, therefore, can be relatively inexpensive to implement. NT plans, in our opinion, are the most flexible, provide asset protection, and can likely provide the best return for physician participants. If building your retirement wealth is an important goal for your financial plan, we highly recommend you investigate NQDC and NT plans to see if they may be right for you.

For a free audio CD on tax, retirement, and asset protection strategies, please call (800) 554-7233 or email: info@wealthprotectionalliance.com

David B. Mandell, JD, MBA is an attorney, lecturer, and author of the books The Doctor's Wealth Protection Guide and Wealth Protection, M.D. He is also a co-founder of The Wealth Protection Alliance (WPA)—a nationwide network of elite independent firms whose goal is to help clients build and preserve their wealth. He offers securities through National Planning Corp. (NPC), Member NASD/SIPC. The WPA and NPC are separate and unrelated companies. To reach David and the Wealth Protection Alliance, please call 800-554-7233.

The information contained in this article is general in nature and should not be construed as comprehensive advice. Please consult a qualified tax, legal or financial advisor before taking any action.



Integrating Injectables into your practice

The prospective patient calls your office.

"Does your doctor inject silicone?" or "Has your office gotten the "new" filler I heard about on Oprah?" Soft tissue fillers have become more mainstream for our patients, for the media, and should be mainstream to the practice of plastic surgery. There have been significant advances in soft tissue fillers over the past several years. What was the hot topic five to ten years ago at the annual meetings is now a dinosaur.

We have seen an increase in the number of available soft tissue fillers as well as a broadening of the indications for specific anatomical sites. Instead of collagen (Zyderm®, Zyplast®, or Cosmoplast®) or hyaluronic acid (Restylane® or Hylaform®), we now speak in terms of PLA microspheres, PMMA microspheres, Ca-HA microspheres, Polyacrylamide gel, Dextran beads, Polyvinyl microspheres, and Hydroxyethyl methacrylate particles. Thankfully, the manufacturers have given us names such as Sculptra®, ArteFill®, Radiesse®, Aquamid®, Matridur®, Evolution®, and Dermalive®. I did not imagine 10 years ago during my fellowship training that the methylmethacrylate I used to fill in bone defects would now be in a microsphere suspension with collagen and injected into the face as "soft" tissue filler.

Injectables such as Botox® are integrated into the majority of plastic surgeons offices either with the physician, PA, or nurse performing the injections. In many offices, the same physician extender may inject soft tissue fillers such as Restylane® or Hylaform®. Generally, the hyaluronic acid fillers are more forgiving in regards to anatomic placement. It has become



generally accepted to perform "off label" injections of products that are touted as being permanent or semipermanent. The injection of permanent or semipermanent fillers has now become highly technique dependent. Lack of experience or proper training may lead the ambitious or cavalier injector to inject Sculptra® or Radiesse® at the same anatomic level as Restylane® and then not know how to deal with the potential visible and/or palpable nodule or papule formation or late granuloma formation.

In my practice, I have seen nodule formation with Sculptra®, especially in the nasojugal fold and along the lateral infraorbital rim. Although published articles recommend a dilute kenalog injection, I have had good luck with lysing the nodule by puncturing it with an insulin syringe filled with sterile water to essentially reconstitute the PLA microspheres in the nodule. This has worked well on two of my patients with nasojugal nodules and several other patients at training visits that had been injected with a "depot" technique in the periorbital region. I do not recommend

the depot technique for Sculptra® in the periorbital region or perioral region. Radially, crosshatched injections of 0.025cc to 0.1cc will create a uniform volumization of the desired area. Local steroid injection should be reserved for granuloma formation, which tends to be a late complication.

Initially, some plastic surgeons may look upon injectables as a waste of their time, that the operating room is the best return on their educational investment. Looking at the costs of each case performed, which would include cost of utilization of the operating room, supplies/implants, anesthesia, overnight or extended stay recovery, and the amount of time each initial consultation, performing the procedure, and follow up care, individual return can be variable.

This compares to initial consultation for an injectable that may be performed the same day and then scheduled for subsequent treatments over an extended period. Published articles reviewing the "Needle versus the knife" have been very informative in regards to incorporating injectables into a practice. The anti-aging movement combined with the retiring baby boomer population has fueled a tremendous growth in the injectable industry. I see many patients in my practice who want to erase the signs of aging and too much sun exposure, but have the expectation that we can accomplish this without surgery. Integrating injectables into your practice will allow you to provide service to these patients as well.

Dr. Joel Shanklin is a member of the Candidate Liaison Committee and a practicing aesthetic surgeon in Savannah, GA

A quality brochure line to **MARKET YOUR PRACTICE**

The Aesthetic Society and ASPS are pleased to announce the creation of a **customizable brochure line** designed to market your practice in a consumer friendly, patient focused way.

These patient marketing brochures are an attractive 8.5x11 size, making them ideal waiting room pieces. They cover some of the most popular aesthetic procedures, including:

- Facial Rejuvenation
- Body Contouring
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Understanding Cosmetic Patients

Continued from Page 5

not. If patients are impressed by how welcome your staff makes them feel and the treatment they get, you are doing a great job. Yet if they aren't wowed on a consistent basis, you may not even be aware until you don't see their names on your daily schedule anymore. Establishing a patient-centric ethos in your practice from day one, and monitoring it closely, has become almost mandatory today.

Increasing competition is driving an interest in measuring patient satisfaction in all aspects of the health care industry. Patient surveys are an effective way of enlightening you about your patients' opinions of both you and your practice, and the results can be a very humbling exercise. Cosmetic patients want and expect better service than in the past, and they know they can get it. Many practices are implementing a service excellence

program to reward the staff for meeting or exceeding the needs and expectations of patients.

Wendy Lewis is an international consultant and writer specializing in all aspects of aesthetic medicine. Ms. Lewis has been a Course Instructor for ASAPS since 2001, and is a frequent presenter at conferences throughout the US and Europe.

1. Pathways to Quality Health Care, Performance Measurement; Accelerating Improvement, INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, THE NATIONAL ACADEMIES PRESS, Washington, D.C. www.nap.edu



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On Establishing a Medical Spa

Continued from Page 9

Community Service and Volunteering

The same community service you have done as a plastic surgeon also applies to your medical spa. Personally I have been quite involved over the past eight years with my foundation, The Image Reborn Foundation of Utah for Breast Cancer Survivors.

All the medical spa employees now participate in volunteering free treatment and services to our monthly breast cancer survivor four day pro bono retreats.

Find your own way to do it and thank your community for your successful practice. Your team will follow you. It is the right thing to do!

The Bottom Line

Jane Crofter summarized very well in her ASAPS Instructional Course why some Medical Spas do well. They are ALL based on a strong medical practice base. They have a committed, highly skilled team and high degree of patient participation. There is an on-going evaluation and modification process with strong supervision and management. I personally like to run it like an operating room.

Most importantly the patients are patients of the "entire entity" and not of the individual doctor, massage therapist or aesthetician.

Promote it as a plastic surgery medical spa and educate your staff and the commu-

nity about what that means!

Finally, DO NOT FORGET THE MAIN BUSINESS which is your very successful Plastic Surgery Practice!

In conclusion, I believe Medical Spas are the ideal environment for preparing patients for plastic and reconstructive surgery for their post operative management and their long term maintenance. In my opinion, Plastic and Reconstructive Surgeons are the most prepared physicians to implement, supervise and run safe medical spas.

Renato Saltz, MD is an aesthetic and reconstructive surgeon in Utah. He also serves as Secretary of the Aesthetic Society and is a member of the Executive Committee.

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Media Notes and Quotes

A Sampling of current media coverage on the Aesthetic Society

A total-body weight-loss plan can help you lose some fat in your neck and face, too. But it won't help you firm up any loose skin left behind, says Dr. Robert Bernard, a plastic surgeon in White Plains NY, and past-president of the American Society for Aesthetic Plastic Surgery. And, unfortunately there are no simple face or neck exercises that help improve appearance or magically reverse aging, according to Bernard. No scientific studies have shown such an approach to work, he notes. "If it was helping I'd have all my patients doing facial exercise before and after surgery," Bernard says. "And I'd be doing them myself every morning."

Fitness fixes for chubby knees, bra bulges?

MSNBC.com

July 1, 2006

The American Society for Aesthetic Plastic Surgery reports that buttock augmentation increased 285 percent from 2002 to 2005. Manufacturers offer padded undergarments and structured jeans to create the illusion of a lifted backside, and at least one woman—known as "Buffy the Body"—has made a career out of marketing the junk in the trunk. "What's happened is the Caucasians now are feeling more and more pressure because it just looks odd to not have buttocks," says Beverly Hills plastic surgeon Anthony Griffin, who pioneered the Brazilian butt lift 10 years ago in the United States. "And of course, there is pressure on people of color because they feel like they should have one."

Society's Singing a New Tune: The Derriere Is Where It's At

Chicago Tribune

July 5, 2006

Doctors say they have patients wanting the features of Jessica Alba and Nicole Kidman. The American Society for Aesthetic Plastic Surgery says plastic surgery jumped more than 400 percent in the past 10 years. In the recent issue of Marie Claire, Ashlee Simpson promoted self-confidence, then got a nose-job. Marie Claire got many angry letters from readers. Joanna Coles, Marie Claire's editor-in-chief, is amazed at the backlash to Marie Claire and Ashlee Simpson due to Simpson's hypocrisy.

CNN Headline News

August 8, 2006

There has always been a cultural debate surrounding cosmetic surgery. The debate swirls around such emotionally charged issues as God-giveness and individual free will. Should one bear for life a physical or mental burden that one was dealt at birth? What constitutes a physical defect? There are questions of masquerade and racial or ethnic passing, as well... The truth is that cosmetic plastic surgery today is almost as accepted as makeup application, hair treatment and orthodontia. Since 1997, there has been 444% increase in the number of cosmetic procedures in the U.S., according to the American Society for Aesthetic Plastic Surgery. Surgical operations have increased 119% since then, while nonsurgical, minimally invasive interventions such as Botox injections, laser hair removal, acid wrinkle fillers, and skin abrasions and peels have shot up 726%.

To Keep or Not To Keep Your Nose

The Los Angeles Times

July 9, 2006

After years of living on the treadmill and devoutly following the South Beach diet in an attempt to shrink our behinds, there are indications that the tyranny of the tiny tush—which so few women naturally have—may finally be ending. The most extreme sign of change comes, as it often does these days, from the operating room: One of the fastest growing plastic surgeries in this country is buttock augmentation. The number of procedures has increased fourfold since 2002, according to the American Society for Aesthetic Plastic Surgery.

Are Butts The New Boobs?

Cosmopolitan

August 2006

"Looking your age is not a great thing in our business." With that in mind, many stars do whatever is necessary to keep their youthful appearances—and their jobs. "Almost nobody [in Hollywood] doesn't get surgery" says Michael McGuire, a Santa Monica plastic surgeon and former president of the California Society of Plastic Surgeons (and the Communications Chair person for the American Society for Aesthetic Plastic Surgery.)

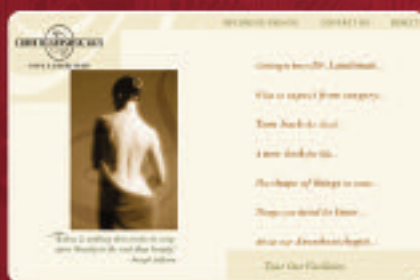
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